

SMITH (Eugene)

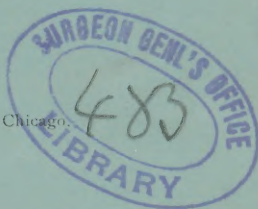
# Jequirity in Granular Lids.

*fm* BY EUGENE SMITH, M.D.,

PROFESSOR OF OPHTHALMOLOGY AND OTOTOLOGY IN DETROIT MEDICAL  
COLLEGE.

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## CHAPTER IV

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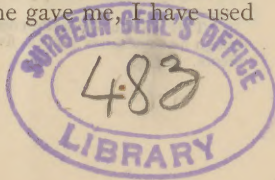
## JEQUIRITY IN GRANULAR LIDS.

During the past year the attention of oculists has been called to the treatment of this intractable disease by an infusion of jequirity seeds, and the profession is indebted to Dr. DeWecker, of Paris, for first bringing it forward in such manner as to make its use promising. Conflicting statements, however, have prevented many from using it, and no doubt the very severe effect of its application in many cases has prevented those testing it from giving it a fair trial.

During my vacation this summer I visited Dr. De Wecker's clinique, and there saw many cases in various stages of treatment, his method of applying it and the results, and I was somewhat astonished at each phase of it.

As trachoma is the *bête noire* of our practice in Michigan, I am deeply interested in its effects, and I feel personally under many obligations to Dr. De Wecker. I believe the profession will, also, for bringing to our notice jequirity.

DeWecker gave me some of the seeds he was using, and instructed me in the manner of using them. Since my return I have used the treatment in twelve eyes, being able to bear him out in most of his statements, so far as such a limited number of cases will permit. Besides the seeds he gave me, I have used



seeds procured from Parke, Davis & Co., chemists, which produced the same effect.

In an article on this subject, DeWecker says in the *Annales d' Oeulistique* for May and June, 1883:

1st. "Incontestably, lotions with the infusion of the seeds of jequirity cause a purulent ophthalmia of croupal character, the intensity of which can be regulated by the number of applications made and the strength of the solution used."

2d. "Incontestably, the cornea runs no risk during the course of jequiritic ophthalmia."

3d. "Incontestably, jequiritic ophthalmia cures granulation rapidly."

In support of DeWecker's conclusions, I can say that in *each* of the cases in which I have used it, I have found the jequiritic ophthalmia assert itself after the *first* application of a three per cent. solution of either a warm or cold infusion.<sup>1</sup> The degree of its activity varied in different cases, but it was active in all. Some individuals seemed more susceptible to its effects than others. In *each* case there was the phlegmonous-like swelling of the lids, with headache and fever, and in several of the cases *nausea* and *vomiting*. The croupal membrane formed on the conjunctiva, and there was a *sero-purulent* discharge instead of one distinctively purulent. The immediate effect of each application lasted several hours, and the applications were made *three times* a day for *three days*—nine applications in all. The effects were

<sup>1</sup> This is the strength commonly used by DeWecker at present, though he sometimes uses a five per cent. solution, closely watching its effects.

then allowed to subside, simply keeping the eyes clean by bathing the lids several times a day in cold water or borated water.

So much for his first proposition. The second proposition—"the cornea does not run any risk from its proper use"—would seem to be supported by the following facts:

On my return home, August 17th, I found in St. Mary's Hospital a Mr. C., aged 73, who had been for about ten days under the care of my assistant for a large asthenic ulcer of the left cornea. About four-fifths of the cornea was affected and nearly necrosed, and in spite of the usual methods of treating such cases, it was proceeding to the bad very rapidly; in fact, I considered the eye lost. I was about to test jequirity in a case of trachoma which I had treated at various times for a year or more, when I thought the case of corneal ulcer was a good one to test the fact of its *danger to the cornea*. I made an application to the conjunctival sac, and laid a sponge wet with the solution on the lids at noon, and ordered an application that evening and next morning. When I saw him at noon next day—just twenty-four hours after *first* dose—there was high fever, nausea, intense shining œdema of the lids, particularly the upper lid, chemosis, and considerable pain when the lids were touched. I stopped the use of the jequirity, and let the patient wash the lids with a solution of boracic acid (about two grains to the ounce), and let the jequiritic inflammation pass off. The progressive tendency of the ulcer seemed checked, and

improvement continued. He was discharged September 4th, about well. In another case I used it three times a day for three days, in a case of ulcerated trachomatous pannus, with a *small prolapse of the iris*, and the ulcer disappeared with the pannus inside of ten days from the time of the use of jequirity.

That corneal trouble may arise, however, and that care must be taken in its use, the following fact shows: A Mr. P., whom I have treated several times during the past year for trachoma, and who has been treated by others for the past three or four years, was placed under the jequirity treatment, a three per cent. solution being used. The lower half of the cornea had seemingly never been affected by the trachoma; the upper half had a thin pannus. As the jequiritic inflammation passed off, the lower half of cornea of right eye was seen to be extremely hazed, almost bordering on an abscess of the cornea in appearance, and looked as if desquamation might take place. It did not, however, and the cornea slowly cleared up. The left eye took the same peculiar course, only perhaps in a severer form, the keretatis being well marked, and was followed by a small but rather deep ulcer, which, without special treatment, has slowly got well, leaving a thin leucoma.

With regard to the third proposition, "It cures granulations rapidly": I have been astonished at the marked effects I have seen in three weeks, as a result of three days' treatment. I have never seen equal results from three months' treatment of similar cases

by any of the usual methods. I think, however, the best results will follow its use in those cases of diffuse thickening of the entire palpebral conjunctiva, without the isolated trachomatous bodies; those which seem to be a general lymph-like infiltration, with trachomatous bodies in the ocular conjunctiva, and possibly in the cornea. In my experience thus far, these are the cases most benefited.

As to its application, I saw DeWecker use a small sponge, with which he made an application to the everted lids, and had the sponge, wet with the infusion, applied to the lids, externally, for five or ten minutes. These applications were made three times a day for three days (nine applications in all). After trying this method I substituted absorbent cotton for the sponge, and I think its use much pleasanter. I find, in order to get the desired effect, it is well (if the swelling of the lid does not prevent) to evert the lids at least the first three or four times of its application, and with a bit of dry absorbent cotton wipe off gently the diphtheritic exudation before applying the lotion. Care must be taken that the sero-purulent discharge does not get into the unaffected eye, as it will set up a similar inflammation, and greatly increase the patient's discomfort. Owing to the severity of its constitutional effect when applied to one eye, it is advisable to treat but one eye at a time. After the severe symptoms pass off, which will be in four or five days, the other eye may be treated. The tendency to posterior symblepharon should be combatted by separating the agglutination with a probe.





